CD-0502-0900p

PO Box 295
Trenton, NJ 08625-0295

DEPARTMENT OF THE TREASURY – DIVISION OF PENSIONS AND BENEFITS

EMPLOYER CERTIFICATION – ACCIDENTAL DEATH ON DUTY

Check one: ☐ PERS ☐ PFRS ☐ TPAF ☐ SPRS

Name of deceased member: _____ Membership No. _____

Position held at time of death: _____

Name of employer: _____ County: _____

Time and date of fatal accident: _____ (Time) ☐ A.M. ☐ P.M. _____ (Day) _____ (Month) _____ (Year)

Exact place of accident: _____ (Street) _____ (City) _____ (State) _____ (County)

Time and date of death: _____ (Time) ☐ A.M. ☐ P.M. _____ (Day) _____ (Month) _____ (Year)

Detailed description of the accident which caused member's death: *(attach additional pages if necessary)* _____

Names and addresses of any witnesses to the accident: _____

Do employer records acknowledge and describe the accident? _____

When was employer's record of the accident made? _____

Was employee hospitalized after accident? ☐ Yes ☐ No If so, name and address of hospital and inclusive dates of hospitalization. _____

Has the employer made an official determination that the member died as a result of an accident arising out of, and in the course of, his employment which was not the result of his willful negligence? ☐ Yes ☐ No. If so, please attach a copy of the official proceedings and the final determination.

Was the employee performing his regular assigned duties at the time of the accident? ☐ Yes ☐ No

The specific duties assigned the employee at the time of the accident were: _____

Employee's immediate supervisor at time of accident: _____ (Name) _____ (Title)

Was an autopsy performed to show cause of death? ☐ Yes ☐ No

I hereby certify that the information shown above is true and correct to the best of my knowledge and belief.

_____ *Certifying Officer's Signature*

_____ *Date*

_____ *Telephone Number*

Please complete this form and return it to the Division of Pensions and Benefits at the address above.